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L6: Entry 33 of 35   File: USPT   Oct 8, 2002

DOCUMENT-IDENTIFIER: US 6463417 B1
TITLE: Method and system for distributing health information

Detailed Description Text (4):
FIG. 2 shows a flow diagram of the method of distributing medical information
according to the present invention. First, the user of the setup system 110, FIG.
1, who can be the patient or the patient's physician, generates security access
codes, step 202, which will provide varying access to the patient's medical
records. Such security access codes can include demographic data such as the
patient's name, birth date, social security number, address and phone number; non-
demographic data such as a passport number and the patient's native language;
physical attributes such as eye and hair color and scars or other identifying
marks; and user-definable fields such as passwords. The user then generates
hierarchical categories into which the patient's medical information will be
stored, step 204. These categories range from a low security category, for
information that the patient is less concerned about becoming known by a third
party, to a high security category, for information that the patient is more
concerned about becoming known by a third party. The patient and/or the patient's
physician then determine the level of privacy that is desired for each piece of
medical information in the patient's medical record, step 206. The least private
level could include information such as the patient's blood type and allergies. The
most private level could include HIV data. Intermediate levels of privacy may
include serology data, psychiatric data, cardiology data and genetic data. After
the levels of privacy for each piece of the patient's medical information is
determined, the information is transmitted from the setup system 110, FIG. 1, to
the server system 120 over the communications network 160, and is stored in a
database 122 of the server system 120, step 208. The patient then assigns one or
more of the security access codes to each of the categories in the database 122,
step 210. Preferably, security access codes that are easier to ascertain are
assigned to low security categories, while security access codes that are more
difficult to ascertain are assigned to high security categories. This allows the
patient to more precisely control who has access to the categories, by enabling the
patient to provide the security access codes for each of the categories only to
medical personnel who have a "need-to-know" the particular information in each
category.

Current US Original Classification (1):
705/2

Refine Search

Search Results -

Terms	Documents
L5 and (705/2).ccls.	35

Database:

US Pre-Grant Publication Full-Text Database
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Search:

L6

Refine Search

Recall Text   Clear   Interrupt

Search History

DATE: Monday, November 12, 2007   **Purge Queries**   Printable Copy   Create Case

Set Name side by side	Query	Hit Count	Set Name result set
	DB=PGPB,USPT; PLUR=YES; OP=OR		
L6	L5 and (705/2).ccls.	35	L6
L5	L4 same (physician$1 or doctor$1)	140	L5
L4	patient$1 with control$4 same medical near3 record$1	483	L4
L3	(6463417 or 6988075).pn.	2	L3
L2	(463417 or 6988075).pn.	1	L2
L1	(463417 or 6988075).pn.6	5283487	L1

END OF SEARCH HISTORY

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L6: Entry 30 of 35   File: USPT   Jan 17, 2006

DOCUMENT-IDENTIFIER: US 6988075 B1
TITLE: Patient-controlled medical information system and method

Brief Summary Text (4):
U.S. Pat. No. 6,018,713 to Coli et al. discloses a network-based system and method
for ordering and reporting the cumulative results of medical tests. The system
includes a computer operated at a physician location (such as a hospital or
physician office) to order tests, retrieve and store statistical data or status the
progress of previously ordered tests, and at least one lab site computer for
receiving physician requests for tests and reporting their results. The physician
computer and lab site computer are interconnected by a computer network. The
physician computer receives a physician or user request for ordering a test, causes
a test request message to be sent to the lab site computer, causes a request for
statistical data to be sent to the network, and receives statistical data from the
network. The lab site computer is programmed to receive a test request message and
to cause a test results message or a test status message to be sent to the
physician computer. The system also includes a patient database computer which
generates longitudinal medical reports, and performs test ordering functions, real
time results reporting, and intelligent physician alerting and decision support
functions, as appropriate in response to requests from other computers in the
system. No patient access to or control of their medical records is disclosed.

Brief Summary Text (7):
U.S. Pat. No. 5,772,585 to Lavin et al. discloses a system and method for managing
patient medical information to facilitate data management and improve physician
access to and recordal of examination data is described. The method comprises a
computer aided process including the steps of scheduling appointments, entering and
displaying data to a physician, updating the patient data with progress notes
concurrently with an examination, displaying allergy warnings and recording a
diagnosis based on the progress notes. A common graphic user interface is also
disclosed to facilitate operation of the preferred system and method. The system
and method are implemented with a relational database operating on data tables
which store information input into the user interface. No patient access to or
control of their medical records is disclosed.

Brief Summary Text (8):
U.S. Pat. No. 5,845,253 to Rensimer et al. discloses system and method for
processing patient data permits physicians and other medical staff personnel to
record, accurately and precisely, historical patient care information. An objective
measure of a physician's rendered level of care, as described by a clinical status
code, is automatically generated. Data elements used in the determination of the
generated clinical status code include a level of history of the patient, a level
of examination of the patient, a decision-making process of the physician treating
the patient, and a "time influence factor." The quantity and quality of care
information for a particular patient is enhanced allowing future care decisions for
that patient to be based on a more complete medical history. Enhanced care
information can be used in outcome studies to track the efficacy of specific
treatment protocols. Archiving of patient information is done in a manner which
allows reconstruction of the qualitative aspects of provided medical services. The
medical care data can be recorded, saved, and transferred from a portable system to

a larger stationary information or database system. No <u>patient</u> access to or <u>control</u> <u>of their medical records</u> is disclosed.

<u>Brief Summary Text</u> (20):
U.S. Pat. No. 5,823,948 to Ross, Jr. et al. discloses a system that provides: automatic incorporation of dictated text; <u>medical records summary generation in</u> <u>medical</u> English text; parsing dictation to data; prephrased text; automatic generation of <u>medical record</u> as consequence of data entry; automatic notation of allergies, significant medical conditions and pregnancy; pregnancy linking, automatically; security card--close on pull; multi-look grease board; outstanding orders listing for all patients in the department; department layout; room selection excludes occupied rooms; nurses notes to text; nurses notes from <u>physician</u> orders to nurses; lab request screen shows all previously ordered labs; therapeutics; ACLS recording; lacerations; <u>doctor</u> specific prescriptions and medication orders; review of systems; coding level alerts; differential diagnosis-- filter to sex and age; diagnosis--fractures to text; <u>doctor</u> interval reexamination; patient instructions predicated on what was done; patient instruction video on demand; patient informed consent video on demand; video teleconferencing; electronic signatures; automatic backup and incremental backup with system on-line; critical management reports; and automatic research data extraction. No <u>patient</u> access to or <u>control of their medical records</u> is disclosed.

<u>Description Paragraph</u> (19):
Patients can access their medical data via a standard Web browser (preferably with strong encryption) and can use server-based software tools (using Java applets, for example) to graphically and textually access their records. Although access is shown through a patient PC 102, any other network-enabled browsing device can be used, including but not limited to hand-held computers (PDAs), WAP-enabled wireless phones, automobile-mounted computers, TV set-top browser systems, and Internet- specific browsing devices. Access can be <u>controlled</u> by a server-set cookie or <u>patient</u>-supplied alphanumeric identifier in combination with a <u>patient</u>-supplied passphrase. FIG. 2 discloses an example of a display screen from a browser 200 for patient access to their <u>medical record</u>. In this example, a patient 201 can access <u>records from various medical</u> events or procedures by selecting hypertext links 210 to view portions of their record. In the disclosed embodiment, hypertext links to the records can be chosen from a chronological table of contents (TOC), or from other categorized sections 220 such as by <u>doctor,</u> by diagnostic test, by prescription, etc. The browser window can also provide a menu 230 for selecting other tools for viewing data from the patient's record.

<u>Current US Cross Reference Classification</u> (1):
<u>705/2</u>